LEGISLATIVE SERVICES AGENCY
OFFICE OF FISCAL AND MANAGEMENT ANALYSIS

301 State House
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FISCAL IMPACT STATEMENT

LS 7428 **DATE PREPARED:** Jan 6, 1999
BILL NUMBER: HB 1333 **BILL AMENDED:**

SUBJECT: Managed Care Organization Liability.

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FUNDS AFFECTED: **X** **GENERAL** **IMPACT:** State & Local
DEDICATED
FEDERAL

Summary of Legislation: This bill provides for a duty of ordinary care for health insurance carriers, health maintenance organizations (HMOs), or other managed care entities when making health care treatment decisions. The bill makes a health insurance carrier, HMO, or other managed care entity liable for harm resulting from health care treatment decisions made without exercising ordinary care. The bill also prohibits these entities from removing a health care provider from, or renewing the status of the health care provider with, the health care plan for advocating on behalf of the insured or enrollee for appropriate and medically necessary care. This bill also prohibits contract indemnification or hold harmless clauses that apply to the acts or conduct of the health insurance carrier, HMO, or other managed care entity.

The bill also establishes the Health Care Appeals Program to provide an independent utilization review of a final decision by a health insurance carrier, HMO, or other managed care entity to deny, reduce, or terminate a benefit. The Department of Insurance is to contract with at least two qualifying independent utilization review agents to provide appeal reviews for the Health Care Appeals Program. Qualifications that a utilization review agent must meet are specified. A utilization review agent is to complete its review and make a determination within 60 days of receiving a completed application for an appeal review and to establish procedures for an expedited review in cases when a delay in receiving a health care service could seriously jeopardize an individual's health or well-being. The bill also requires the utilization review agent to state its findings and recommendations in writing and makes the decision of the utilization review agent binding on the health insurance carrier, HMO, or other managed care entity.

The bill also provides that all records associated with an appeal review are confidential. The Commissioner of the Department of Insurance is to establish a reasonable, per case reimbursement schedule for utilization review agents. It also provides that the health insurance carrier, HMO, or other managed care entity that is the subject of an appeal review is responsible for paying the reasonable expenses of the utilization review agent that conducted the appeal review. The Department of Insurance is to file reports with the General Assembly every six months detailing the activity of the Health Care Appeals Program.

Effective Date: July 1, 1999.

Explanation of State Expenditures: This bill establishes the Health Care Appeals Program to provide an independent utilization review of a final decision by a carrier who denies, reduces, or terminates benefits and that is contested by an enrollee. The Insurance Commissioner is to contract with two or more utilization review agents for review of adverse utilization reviews and medical necessity determinations. The cost of contracting with utilization review agents is estimated to cost about $85,000 annually. The carrier that is the subject of an appeal review is responsible for paying the reasonable expenses of the utilization review agent.

This bill also provides that insurance carriers and managed care organizations have the duty to exercise ordinary care when making health care treatment decisions and makes them liable for harm to an insured or enrollee that is proximately caused by the failure of the insurance carrier or managed care organization to exercise ordinary care. These provisions may result in additional litigation and claims expenses and additional costs for malpractice insurance to the health plans offered to state employees. The increased costs may be reflected in increased premiums and enrollment fees. Increased premiums and fees, however, may or may not result in additional costs to the state, depending upon administrative action as to the determination of the employer/employee cost share for health plan benefits.

Explanation of State Revenues: The bill provides for fees and penalties, including: (1) a $25 application fee to be paid by the enrollee contesting the decision of the carrier; (2) reimbursement by carriers for the reasonable expenses associated with the utilization review agent; and (3) penalties and sanctions imposed on carriers by the Department of Insurance for violation of patient rights or other relevant rules. Fees and monetary penalties would be deposited into the state General Fund.

Explanation of Local Expenditures: Similar to the state, increased premiums and enrollment fees arising from additional litigation and claims expenses and additional costs for malpractice insurance, may or may not result in additional costs to local governments and school corporations, depending upon administrative action as to the determination of the employer/employee cost share for health plan benefits offered to employees.

Explanation of Local Revenues:

State Agencies Affected: Department of Insurance

Local Agencies Affected: Local Governments and School Corporations

Information Sources: Liz Carroll, Department of Insurance, 232-2406.